Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

STEPHEN E EARLE MD
PO BOX 33577
SAN ANTONIO TX 78265

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-08-6659-01

MFDR Date Received
JULY 10, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Each one of these codes was preauthorized and cannot be denied by medical necessity per TDI-DWCC Guidelines."

Amount in Dispute: $5868.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual authorized codes 22899, 63030, 63035, 62290, 69990, and 22612."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 2, 2008	CPT Code 22899-99	$525.00	$0.00
	CPT Code 63035-50	$122.18	$115.32
	CPT Code 63035-22	$237.51	$0.00
	CPT Code 62290	$201.94	$0.00
	CPT Code 62290-59	$201.94	$0.00
	CPT Code 62290-22	$201.94	$0.00
	CPT Code 22325-59	$768.77	$0.00
	CPT Code 22328-59	$334.20	$0.00

January 2, 2008	CPT Code 22851-50	$495.16	$0.00
	CPT Code 22851-22	$495.16	$0.00
	CPT Code 22842-22	$495.16	$0.00
	CPT Code 20975	$103.00	$0.00
	CPT Code 63685-59	$278.21	$0.00
	CPT Code 63011-59	$600.74	$0.00
	CPT Code 63011	$600.74	$598.08
	CPT Code 69990-59	$131.93	$0.00
TOTAL		$5,868.18	$713.40

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.202, effective August 1, 2003, sets the reimbursement guidelines for the disputed services.
3. 28 Texas Administrative Code §134.600, effective May 2, 2006, requires preauthorization for specific treatments and services.
4. 28 Texas Administrative Code §134.1, effective May 2, 2006, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
5. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - Cage placement is per level and not per cage.
   - CAC- W1-Workers Compensation state fee schedule adjustment.
   - CAC-151-Payment adjusted because the payer deems the information submitted does not support this many services.
   - CAC-97-Payment is included in the allowance for another service/procedure.
   - 217-The value of this procedure is included in the value of another procedure performed on this date.
   - 298-Only one is allowed per date of service.
   - 435-Per NCCI Edits, the value of this procedure is included in the value of the comprehensive procedure.
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
   - 930-Pre-authorization required, reimbursement denied.
   - 891-The insurance company is reducing or denying payment after reconsideration.
   - CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration.
   - CAC-197-Payment adjusted for absence of precertification/authorization/notification. This change effective 4/1/2008: Precertification/authorization/notification absent.

Issues

1. Is the respondent's response to the dispute in accordance with 28 Texas Administrative Code §133.307?
2. Did the requestor obtain preauthorization for CPT codes 62290, 62290-59, 62290-22, 20975, and 63685-59?
3. Per NCCI Edits are CPT codes 22899-99, 63035-50, 62290-59, 22325-59, 22328-59, 22851-50, 22851-22, 63035-22, 63011, 63011-59, and 69990 global to/included in another procedure?
4. Is the requestor entitled to reimbursement for CPT code 22899-99?

5. Is the requestor entitled to reimbursement for CPT codes 63035-50 and 63035-22?
6. Is the requestor entitled to reimbursement for CPT code 22325-59?
7. Is the requestor entitled to reimbursement for CPT code 22328-59?
8. Is the requestor entitled to reimbursement for CPT codes 22851-50 and 22851-22?
9. Is the requestor entitled to reimbursement for CPT code 22842-22?
10. Is the requestor entitled to reimbursement for CPT code 63011-59?

Findings

1. 28 Texas Administrative Code §133.307 (d)(2)(B) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MDR will be dismissed in accordance with subsection (e)(3)(G) or (H) of this section."

   The respondent states in the position summary that preauthorization was not obtained for codes: 22851-50, 22851-59, 22851-22, 22842, 22842-22, 20975, 22585, 22585-59, 22614, 22614-59, 22851, 62290-59, 62290-22, 22325-59, 22328-59, 22558, 99220, 63035-50, 63035-59, 63035-22, 63011, 63011-59, 20938, and 63685-59.

   However, according to the explanation of benefits, only CPT codes 62290, 62290-59, 62290-22, 20975, and 63685-59 were denied reimbursement based upon reason code "930." Therefore, the Division is prohibited from considering in the review this new denial reason or defenses for CPT codes : 22899-99, 63035-50, 63035-22, 22325-59, 22328-59, 22851-50, 22851-22, 22842-22, 63011-59, 63011 and 69990-59.

2. According to the explanation of benefits, the respondent denied reimbursement for CPT codes 62290, 62290-59, 62290-22, 20975, and 63685-59 based upon reason codes "930 and CAC-197."

   28 Texas Administrative Code §134.600(c)(1)(B) states "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur:

   (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

   The requestor states in the position summary that "Each one of these codes was preauthorized and cannot be denied by medical necessity per TDI-DWCC Guidelines."

   The respondent states in the position summary that "Texas Mutual authorized codes 22899, 63030, 63035, 62290, 69990, and 22612."

   28 Texas Administrative Code §134.600 (f)(1) and (2) states "The requestor or employee shall request and obtain preauthorization from the carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent review shall be sent to the carrier by telephone, facsimile, or electronic transmission and, include the:

   (1) specific health care listed in subsection (p) or (q) of this section;

   (2) number of specific health care treatments and the specific period of time requested to complete the treatments."

   On December 3, 2007, the requestor obtained preauthorization approval for inpatient lumbar spine, LOS x2, for CPT codes: 22899, 63030, 63035, 69990, 62290 and 22612.

   The requestor did not support position that preauthorization was obtained for CPT codes 20975, and 63685-59 in accordance with 28 Texas Administrative Code §134.600 (f)(1) and (2); therefore, reimbursement is not recommended for these codes.

3. According to the explanation of benefits, the respondent denied reimbursement for CPT codes 22899-99, 63035-50, 62290-59, 22325-59, 22328-59, 22851-50, 22851-22, 63035-22, 63011, 63011-59, and 69990 based upon reason codes "97, 217, and/or 435."

   On the disputed date of service the requestor billed the following codes: 99220, 22899-99, 63030, 63030-50, 63035, 63035-50, 62290, 62290-59, 62290-22, 22325-59, 22328-59, 22558, 22585, 22585-59, 22612, 22614, 22614-59, 22851, 2285150, 22851-59, 22851-22, 22842, 22842-22, 20975, 63685-59, 63035-59, 63035-22, 63011, 63011-59, 69990-59 and 20938.

Per NCCI edits, CPT code 62290 is global to CPT code 63030. A modifier is not allowed to differentiate the service; therefore, the respondents denial of CPT codes 62290, 62290-59, 62290-22 is supported, and reimbursement cannot be recommended.

Per NCCI edits, CPT code 69990 is global to CPT code 22612. A modifier is not allowed to differentiate the service; therefore, the respondents denial of CPT code 69990-59 is supported, and reimbursement cannot be recommended.

The respondent did not support the denial of CPT codes 22899-99, 63035-50, 22325-59, 22328-59, 22851-50, 22851-22, 63011, and 63011-59 based upon reason codes "97, 217, and/or 435." These codes will be reviewed per applicable Division rules and guidelines.

4. According to the explanation of benefits, the respondent denied reimbursement for CPT code 22899-99 based upon reason code "97 and 217." As stated above, per NCCI edits this code is not global to any other code billed on this date.

   The requestor indicates in the position summary that CPT code 22899-99 was used for "examination under anesthesia and pain study".

   The respondent states in the position summary that "Code 22899-99: An examination under anesthesia is not a separately payable service because an examination is part and parcel of the spinal surgery procedures performed. Further, Medicare gives code 22899 a 'C status, which means the insurance carrier prices the individual code generally on an individual basis. In the instance case Texas Mutual priced the amount as $00.00."

   28 Texas Administrative Code §134.202(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section."

   28 Texas Administrative Code §134.202(c)(6) states "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments."

   CPT code 22899 is defined as "Unlisted procedure, spine." The requestor appended modifier -99 defined as "Multiple Modifiers." A review of the medical bill does not support the use of modifier 99.

   CPT code 22899 does not have a relative value unit assigned; therefore, reimbursement shall be provided in accordance with 28 Texas Administrative Code §134.1.

   This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1 that "requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

   28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

   - The requestor asks to be reimbursed the full amount of the billed charges in support of which the requestor states "Surgery was Pre-authorized and injury is compensable."
   - The requestor does not discuss or explain how reimbursement of $525.00 for code 22899-99 is a fair and reasonable reimbursement.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and

reasonable rate of reimbursement for the services in this dispute.

- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

5. According to the explanation of benefits, CPT code 63035-50 and 63035-22 were denied reimbursement based upon reason codes "97 and 217". As stated above, per NCCI edits this code is not global to any other code billed on this date.

   CPT code 63035 is defined as "Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)."

   A review of the medical bill indicates the requestor billed CPT code 63035, 63035-50, 63035-22, and 63035-59. The respondent paid for CPT code 63035 and 63035-59.

   The requestor appended modifiers"50-Bilateral Procedure" and "22-Increased Procedural Service" to CPT code 63035.

   Modifier 22 is required "When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required)." A review of the operative report does not support the use of modifier -22, specifically "the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required"; therefore, reimbursement is not recommended for CPT code 63035-22.

   The respondent states in the position summary that "Texas Mutual paid the first billing of this code for L4-5 at the MAR of $230.65 and the second level, L5-S1, at the MAR of $230.65. Texas Mutual believes not further payment is due."

   The operative report indicates that the laminectomy was performed bilaterally at both levels; therefore, the requestor supported the use of modifier 50 and reimbursement is due for CPT code 63035-50.

   Per Rule 134.202(b), the maximum allowable reimbursement, (MAR) is determined by locality. A review of Box 32 on CMS-1500 indicates that the zip code 78233 is the locality. This zip code is located in Bexar County.

   28 Texas Administrative Code §134.202(c)(1) states "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: "for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%."

   The Medicare allowable for CPT code 63035-50 in Bexar County is $184.52. Per 28 Texas Administrative Code §134.202(c)(1) this amount is multiplied by 125% equals a MAR of $230.65. The requestor billed for this procedure bilaterally therefore, this amount multiplied by 150% = $345.97. The difference between the MAR and amount paid is $230.65. As a result, the amount ordered is $115.32.

6. According to the explanation of benefits, the respondent denied reimbursement for CPT code 22325-59 based upon reason codes "97 and 217." As stated above, per NCCI edits this code is not global to any other code billed on this date.

   CPT code 22325-59 is defined as "Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; lumbar."

   The requestor appended modifier -59 to CPT code 22325. Modifier -59 is defined as "Distinct Procedural Service". Modifier 59 is further defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session,

different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

The operative report indicates that "The patient has manual reduction of the subluxation at L4-5 and L5-S1 into anatomic position in the axial, coronal, and sagittal plane." The operative report does not support the use of modifier 59; therefore, reimbursement is not recommended.

7. According to the explanation of benefits, the respondent denied reimbursement for CPT code 22328-59 based upon reason codes "97 and 217." As stated above, per NCCI edits this code is not global to any other code billed on this date.

   CPT Code 22328 is defined as "Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; each additional fractured vertebra or dislocated segment (List separately in addition to code for primary procedure)."

   The requestor appended modifier -59 to CPT code 22328. Modifier -59 is defined as "Distinct Procedural Service". Modifier 59 is further defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

   The operative report indicates that "The patient has manual reduction of the subluxation at L4-5 and L5-S1 into anatomic position in the axial, coronal, and sagittal plane." The operative report does not support the use of modifier 59; therefore, reimbursement is not recommended.

8. According to the explanation of benefits, CPT code 22851-50 and 22851-22 were denied reimbursement based upon reason codes "97 and 217". As stated above, per NCCI edits this code is not global to any other code billed on this date.

   CPT code 22851 is defined as "Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)."

   A review of the medical bill indicates the requestor billed CPT code 22851, 22851-50, 22851-22, and 22851-59. The respondent paid for CPT code 22851 and 22851-59.

   The requestor appended modifiers"50-Bilateral Procedure" and "22-Increased Procedural Service" to CPT code 22851.

   Modifier 22 is required "When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required)." A review of the operative report does not support the use of modifier -22, specifically "the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required"; therefore, reimbursement is not recommended for CPT code 22851-22.

   The respondent states in the position summary that "Code 22851-50 and 22851-22: These codes were not preauthorized yet Texas Mutual initially issued payment of $480.83 for both codes. In the absence of any substantial argument from the requestor as to why this non-authorized code should be paid, Texas Mutual believes no further payment is due."

   The operative report indicates that "the patient had cage placement at L4-L5 and L5-S1 initially on the patient's left side and subsequently on the patient's right side with a 12-mm x 22-mm cage at L4-L5 and 10-mm x 22-mm cage at L5-S1. This was performed bilaterally."

   According to the American Medical Association 2008 CPT book, CPT code 22851 should not be used in conjunction with CPT code 22842. In addition, according to the Medicare Physician Fee Schedule Database, a -50 modifier may not be added on the procedure code 22851; therefore, reimbursement is not recommended.

9. According to the explanation of benefits, the respondent denied reimbursement for CPT code 22842-22 based upon reason codes “151 and 298.”

   CPT code 22842 is defined as “Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure).”

   A review of the medical bill indicates the requestor billed CPT code 22842 and 22842-22.

   The requestor appended modifier “22-Increased Procedural Service” to CPT code 22842.

   Modifier 22 is required “When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required).” A review of the operative report does not support the use of modifier -22, specifically “the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required.”

   A review of the operative report indicates “The patient had pedicle screw placement at L4-L5 in the sacrum bilaterally using 6.5-mm x 40-mm screw at L4 and L5 with 7.5-mm x 35-mm screw at the sacrum…The patient had selection of 70-mm curved rods, which were fixed under compression with locking pins. Additional crosslink placed at L4-5 and L5-S1.”

   The operative report supports billing of posterior segmental instrumentation to L4-L5 and L5-S1. The respondent paid for CPT code 22842. The documentation does not support billing of CPT code 22842-22; therefore, reimbursement is not recommended.

10. According to the explanation of benefits, the respondent denied reimbursement for CPT code 63011-59 based upon reason codes “97 and 217.” As stated above, per NCCI edits this code is not global to any other code billed on this date.

    CPT code 63011 is defined as “Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; sacral.”

    A review of the medical bill indicates the requestor billed CPT code 63011 and 63011-59.

    The operative report indicates that claimant underwent “Decompressive laminectomy of the sacrum, decompression of the S1 nerve roots, and cauda equine with neural foraminotomy S1 nerve roots bilaterally.”

    The requestor appended modifier -59 to CPT code 63011. Modifier -59 is defined as “Distinct Procedural Service”. Modifier 59 is further defined as “Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.”

    The operative report does not support the use of modifier 59; therefore, reimbursement is not recommended for CPT code 63011-59.

    The operative report does support billing of CPT code 63011; therefore, reimbursement is recommended.

    The Medicare allowable for CPT code 63011 in Bexar County is $956.94. Per 28 Texas Administrative Code §134.202(c)(1) this amount is multiplied by 125% equals a MAR of $1,196.17. This code is subject to multiple procedure discounting; therefore, the MAR is $598.08. The difference between the MAR and amount paid is $598.08. As a result, the amount ordered is $598.08.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $713.40.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $713.40 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		2/12/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.